☐ Medicare # _____ ☐ Other 3rd Party ID# _____ ☐ Cash

Screening Questionnaire, Consent and Physician Fax Form

Patient Information: (Patient to complete*)

*Patient Name: _____ *Date of Birth: _____ *Phone# _____

*Address: _____ *City: _____ *State: _____ *Zip:_____

*Gender: M or F *Primary Doctor: _____ *Dr. Phone: _____

* Alt Doctor: _____ *Dr. Phone: _____

*Which vaccine(s) would you like to receive today? _____

*Medical Conditions: _____ *Enter Weight if less than 110 lbs: _____

Pharmacy Use Only Dr Fax: _____ Rite Aid Associate # _____

Dear Doctor: Today the above patient was vaccinated with the following immunizations at our store, please retain for your records.

☐ Influenza Injectable	VIS Date:		☐ Meningococcal	VIS Date:		☐ Zoster (Shingles)	VIS Date:	
☐ Pneumococcal	VIS Date:		☐ Td	VIS Date:		☐ Tdap	VIS Date:	
☐ Hepatitis B	VIS Date:		☐ Hepatitis A	VIS Date:		☐ Hepatitis A & B	VIS Date:	
☐ HPV	VIS Date:		☐ MMR	VIS Date:		☐ Influenza Nasal	VIS Date:	
☐ Varicella	VIS Date:		☐ DTaP:	VIS Date:		☐ Hib:	VIS Date:	
☐ IPV:	VIS Date:		☐ Other:	VIS Date:		☐ Other:	VIS Date:	

Place RX Label Here

Place RX Label Here

Date VIS was given to patient: _____ Date VIS was given to patient: _____

Lot # _____ Lot # _____

Exp Date: _____ Exp Date: _____

Site LA or RA (Circle one) Site LA or RA (Circle one)

Signature of pharmacist who administered Vaccine(s): _____ License #: _____ Date: _____

Patient Information: (Patient to complete this section.)

The following questions will help us determine which vaccines may be given today. If a question is not clear, please ask your pharmacist to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food (ie. eggs), latex or any vaccine (i.e. neomycin)?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments:	☐	☐	☐
6. During the past year, have you received a transfusion of blood or blood products, including antibodies?	☐	☐	☐
7. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐
8. Do you have a neurological disorder such as seizures or other disorders that affect the brain or have a neurological disorder that resulted from a vaccine?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant in the next three months?	☐	☐	☐
10. Did you bring your Immunization Record Card with you?	☐	☐	
11. I request that the pharmacist **DOES NOT** send a copy of my vaccine document to my primary care provider (if state regulations allow).	☐	☐	

It is important for you to have a personal record of your vaccinations. If you don't have an immunization record card, ask your pharmacist to give you one. Bring this record with you every time you seek medical care.

- Medicare Part B patients authorize the release of any medical or other information to process this claim and request payment of government benefits to either themselves or the party who accepts assignment below.
- If the patient's insurance does not cover the cost of administering the vaccine at the pharmacy, then payment must be made at the time of the administration of the vaccine.
- The Pharmacist recommends and encourages our vaccinated patient to remain in the waiting area, post immunization, for 20 minutes.
- I have read, or have had read to me the Vaccination Information Sheet (VIS) regarding the vaccine(s). I have had the opportunity to ask questions that were answered to my satisfaction and understand the benefits and risks of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s). I fully release and discharge Rite Aid Corporation, it affiliates, their officers, directors, and employees from any liability for illness, injury, loss, or damage which may result there from.

Patient Signature (If under the age of 18: Parent/legal guardian signature)**:** _____